CONFIDENTIAL MEDICAL HISTORY FORM

To obtain the best and safest treatment, your dentist needs to know any problems which may affect your treatment. Please write your contact details below answer the health question and sign the bottom of the form.

All information will be kept strictly confidential!

Title	Mr/ Mrs/ Miss/ Ms/ other please specify.....	☐ Male	☐ Female
Surname		Date of Birth	
Forename			
Address		Post Code	
Telephone Numbers	Home:	Mobile Phone	
	Work:	E-mail Address:	
Occupation			
Old Dentist's Name, Address & Tel No.			
Approx date of last dental treatment			
Doctor's (GP) Name, Address & Tel. No.			

ARE YOU CURRENTLY	**YES**	**NO**	**PLEASE GIVE DETAILS**
Pregnant?			
Receiving treatment from a Doctor, hospital or clinic?			
Taking any prescription medicines e.g. tablets, ointment, injection or inhalers, including contraceptive or hormone replacement therapy?			
Carrying a warning card?			
DO YOU SUFFER FROM:	**YES**	**NO**	**PLEASE GIVE DETAIILS**
Allergies to any medicines e.g. antibiotics, substance such as latex/rubber or foods?			
Hay fever or eczema?			
Bronchitis, asthma or other chest conditions?			
Fainting attack, giddiness, blackouts or epilepsy?			
Heart problems, angina, blood pressure problems or stroke?			
Diabetes or does anyone in your family?			
Arthritis?			
Bruising or persistent bleeding following injury, tooth extraction or surgery?			
Any infectious diseases? (Including HIV or hepatitis)?			
DID YOU, AS A CHILD OR SINCE HAVE:	**YES**	**NO**	**PLEASE GIVE DETAILS**
Rheumatic fever or chorea?			
Liver Disease e.g. jaundice, hepatitis or Kidney disease?			
Any other serious illness?			
Blood refused by the Blood Transfusion Service?			
A bad reaction to general or local anaesthetic?			

A joint replacement or other implants?			
Treatment that required you to be in hospital?			
Heart Surgery?			
Brain Surgery?			
Growth hormone treatment before the mid 1980's?			
A close relative (parent, sibling, child, grandparent or grandchild) with creutzfeldt jakob disease ?			
DRINKING:			
How many units of alcohol do you drink per a week? (A unit is half a pint of lager, a single measure of spirits or a single glass of wine/aperitif).			

SMOKING AND CHEWING:	**YES (Quantity)**	**NO**	**IN PAST (Quantity)**
Do you smoke any tobacco products now or did you in the past?			
Do you chew tobacco, pan or supari now or did you in the past?			
Please give any other details which your dentist might need to know about such as self prescribed medicine (e.g. aspirin).			

By completing this medical history form you agree to receive your dental care under **a private contract**.

Please indicate if you are interested in the following types of <u>private</u> dental treatment;

☐ Seeing the dental hygienist ☐ Dental implants ☐ Tooth Whitening
☐ Invisalign Treatment ☐ Other (please specify)…….

How did you hear about the practice?

Please tell the dentist if you have a disability that the practice should be aware of to ensure that our services are appropriate to your needs

We may use your email for promotional and marketing purposes, If you wish to opt out of this service please tick this box ☐

Completed by (please tick)	☐ Self	☐ Parent	☐ Guardian
Signature:			Date: